

# APPLICATION FOR COMPETITIVE ATHLETIC EVENT PHYSICIAN REGISTRATION



**MINNESOTA BOARD OF MEDICAL PRACTICE**  
**UNIVERSITY PARK PLAZA**  
**2829 UNIVERSITY AVENUE SE, SUITE 500**  
**MINNEAPOLIS, MINNESOTA 55414-3246**  
**612-617-2130 or [www.bmp.state.mn.us](http://www.bmp.state.mn.us)**

Hearing Impaired-Minnesota Relay Service  
 Metro Area 297-5353  
 Outside Metro Area 1-800-627-3529

FOR BOARD USE ONLY

APPLICATION #: \_\_\_\_\_

CHECK/RECEIPT #: \_\_\_\_\_

AMT PAID: \_\_\_\_\_

REG #: \_\_\_\_\_

APPROVE DATE: \_\_\_\_\_

**DATE OF APPLICATION:**

MONTH	DAY	YEAR

## INSTRUCTIONS TO APPLICANT

1. Enter all dates as Month/Day/Year.
2. Please type or print and answer all questions completely and accurately. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently registered by the Board.
3. Application fee is \$50.00. This fee is not refundable and must be in U.S. currency. Please make checks payable to the **Minnesota Board of Medical Practice**.
4. Incomplete applications will be returned for completeness.

SOURCE CODE	AMOUNT
635038	

## YOUR CURRENT NAME AND ADDRESS

FULL LEGAL NAME:		LAST	FIRST	MIDDLE
STREET ADDRESS:				
CITY:	STATE OR PROVINCE:	ZIP CODE:	COUNTRY:	
HOME PHONE:	WORK PHONE:	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	OTHER NAMES:	
SOCIAL SECURITY #:	DATE OF BIRTH:	LICENSED IN THE STATE OF:	LICENSE #	

## MEDICAL SCHOOL

NAME OF SCHOOL:	CITY:	STATE OR PROVINCE:	COUNTRY:	DATE OF GRADUATION (Month / Day / Year)
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## ATHLETIC EVENT

NAME AND LOCATION OF ATHLETIC EVENT:	FOR THE PERIOD: (Month-Day-Year)	
	START DATE:	END DATE:

I have read Minnesota Statute §147 and will comply with the provision therein.

Signature \_\_\_\_\_ Date \_\_\_\_\_